SERFF Tracking Number:	*FHLA-128460058*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:	*ARL4APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Whole Life Applications*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Family Heritage Life Insurance Company of America

Product Name: Whole Life Applications	SERFF Tr Num: FHLA-128460058	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: ARL4APP	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Kevin Wicktora, Kim Scott	Disposition Date: 06/11/2012
	Date Submitted: 06/08/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 06/11/2012
	State Status Changed: 06/11/2012
Deemer Date:	Created By: Kevin Wicktora
Submitted By: Kevin Wicktora	Corresponding Filing Tracking Number:

Filing Description:

Family Heritage Life Insurance Company of America would like to file the following forms for your review and approval:

Form Number ----- Description
FORM L4APP-AR2 Whole Life Application
FORM L5APP-AR Whole Life Application
FORM L4SPP-ST2 Conditional Receipt / MIB Disclosure
FORM L4CIN-AR Consumer Information Notice

SERFF Tracking Number:	*FHLA-128460058*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:	*ARL4APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Whole Life Applications*		
Project Name/Number:	*/*		

These forms will be used with individual whole life policy L4POL-AR which was approved by the Department on 6/28/2007.
State Narrative:

Company and Contact

Filing Contact Information

Kevin Wicktora, Compliance Manager
6001 East Royalton Road
Suite 200
Cleveland, OH 44147

kevin.wicktora@familyheritagelife.com
440-922-5134 [Phone]

Filing Company Information

Family Heritage Life Insurance Company of America
6001 East Royalton Road
Suite 200
Cleveland, OH 44147
(440) 922-5200 ext. [Phone]

CoCode: 77968
Group Code:
Group Name:
FEIN Number: 34-1626521

State of Domicile: Ohio
Company Type: Life & Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Family Heritage Life Insurance Company of America	$50.00	06/08/2012	59990172
Family Heritage Life Insurance Company of America	$150.00	06/08/2012	59997660

SERFF Tracking Number:	*FHLA-128460058*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:	*ARL4APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Whole Life Applications*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/11/2012	06/11/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Linda Bird	06/08/2012	06/08/2012	Kevin Wicktora	06/08/2012	06/08/2012

SERFF Tracking Number:	*FHLA-128460058*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:	*ARL4APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Whole Life Applications*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 06/11/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FHLA-128460058*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:	*ARL4APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Whole Life Applications*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Whole Life Application		Yes
Form	Whole Life Application		Yes
Form	Conditional Receipt / MIB Disclosure		Yes
Form	Arkansas Consumer Information Notice		Yes

SERFF Tracking Number:	*FHLA-128460058*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:	*ARL4APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Whole Life Applications*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/08/2012
Submitted Date	06/08/2012
Respond By Date	07/09/2012

Dear Kevin Wicktora,

This will acknowledge receipt of the captioned filing.

Objection 1
Comment:
Regulation 57 was revised effective January 2010, the filing fee is now $50.00 per form. We will hold your filing in a pending status until the additional $150.00 is received.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

SERFF Tracking Number:	*FHLA-128460058*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:	*ARL4APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Whole Life Applications*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/08/2012
Submitted Date	06/08/2012

Dear Linda Bird,

Comments:

Response 1

Comments: An additional $150.00 has been submitted via EFT.

Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now $50.00 per form. We will hold your filing in a pending status until the additional $150.00 is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you.

Sincerely,
Kevin Wicktora, Kim Scott

SERFF Tracking Number:	*FHLA-128460058*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:	*ARL4APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Whole Life Applications*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: FORM L4APP-AR2

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FORM L4APP-AR2	Application/ Enrollment Form	Whole Life Application	Initial			FORM L4APP-AR2.pdf
	FORM L5APP-AR	Application/ Enrollment Form	Whole Life Application	Initial			FORM L5APP-AR.pdf
	FORM L4SPP-ST2	Other	Conditional Receipt / MIB Disclosure	Initial			FORM L4SPP-ST2.pdf
	FORM L4CIN-AR	Other	Arkansas Consumer Information Notice	Initial			FORM L4CIN-AR.pdf

FAMILY HERITAGE®
Life Insurance Company Of America

Application For **Heritage Life Extra** Whole Life Insurance
Life Administrative Office: P.O. Box 5128, Frankfort, KY 40602-5128

Proposed Insured Information

First Name	MI	Maiden Name	Last Name	☐ Male ☐ Female
Date of Birth	Birthplace (City & State)	Height ft in	Current Weight lbs	
Phone Number ( ) -	SSN	Driver's License Number	Issue State	
Address	City	County	State	Zip Code
Primary Physician's Name	Address	Phone Number ( ) -		

Beneficiary Information

Primary Beneficiary Name	Relationship	SSN	Contingent Beneficiary Name	Relationship

Proposed Owner (If other than Proposed Insured)

First Name	MI	Last Name	SSN	Date of Birth	Relationship

Mailing Address	City	County	State	Zip Code	Phone Number ( ) -

Has the Proposed Insured:	**YES**	**NO**
1. In the past **2 years** used nicotine in any form including: cigarettes, cigars, pipe, chewing tobacco, snuff, gum, lozenge or patch?	☐	☐
2. Been actively at work (at least 30 hours per week) for the past **12 months** (excluding non-working spouses)?	☐	☐

Has the Proposed Insured or any Child to be covered under this policy:	**YES**	**NO**
3. In the past **12 months**, been confined for 24 hours or more, or been advised by a medical professional to be confined to a hospital, nursing home, psychiatric facility, or assisted living facility excluding i) confinements for: childbirth, gall bladder surgery, appendix surgery, broken bones or back problems; and ii) for which the proposed insured has completely recovered?	☐	☐
4. **Ever** had or been advised by a medical professional to have an organ or tissue transplant; of having any illness indicated as being terminal; or of having a life expectancy of two years or less?	☐	☐
5. In the past **10 years** been diagnosed with, treated for, or taken prescription drugs for any of the following:		
a. Cancer in any form other than basal cell skin cancer?	☐	☐
b. Chronic obstructive pulmonary disease (COPD), emphysema, pulmonary fibrosis, chronic bronchitis or chronic asthma (excluding mild asthma requiring occasional inhaler use)?	☐	☐
c. Heart disease (including heart attack, heart surgery, congestive heart failure, coronary artery disease or angina)?	☐	☐
d. Uncontrolled high blood pressure or malignant hypertension?	☐	☐
e. Insulin dependent diabetes?	☐	☐
f. Multiple sclerosis, Parkinson's disease, systemic lupus, or Lou Gehrig's disease (ALS)?	☐	☐
g. Kidney disease, liver disease, cirrhosis, chronic hepatitis, or hepatitis C?	☐	☐
h. Stroke, transient ischemic attack (TIA) or mini-stroke?	☐	☐
i. Alcohol or drug abuse?	☐	☐
j. Alzheimer's disease, dementia, organic brain syndrome, or brain tumor?	☐	☐
k. Major depression, bipolar disorder, or schizophrenia?	☐	☐
l. Down Syndrome, spina bifida, muscular dystrophy, or sickle cell anemia?	☐	☐
6. In the past **12 months,** been advised by a medical professional to have a diagnostic test or surgery that has not been performed or for which results have not been received?	☐	☐

Has the Proposed Insured or any Child to be covered under this policy:	YES	NO
7. Had a seizure of any type in the past **2 years**?	❑	❑
8. **Ever** been diagnosed with any immune deficiency including AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?	❑	❑
9. In the past **12 months** worked for pay as a timber cutter, logger, commercial fisherman, or aircraft pilot?	❑	❑
10. Within the past **3 years** been convicted of operating a vehicle while under the influence of drugs or alcohol, been convicted of reckless driving, or had a suspended or revoked driver's license?	❑	❑
11. **Ever** been convicted of a felony and currently in prison, on probation or on parole?	❑	❑

Other	YES	NO
12. Are you or any Child to be covered under this policy a permanent resident of the United States, the United States Protectorates or Canada?	❑	❑
13. Do you have any existing life insurance or annuity contracts in force? (If "Yes" complete a Replacement Form)	❑	❑
14. Do you give Family Heritage permission to show your name for marketing purposes?	❑	❑

Covered Children Information List the names of all children to be covered under this plan. (Additional space provided below if needed.)
Only dependent children are eligible.

Name (Please Print: First, Middle Initial, Last)	M/F	Date of Birth	Physician's Name

Insurance Applied For

	Ages 23 through 55			Ages 56 and Older		
	Whole Life		**Term Rider With ROP**	**Whole Life**	❑ **Accidental Death Rider**	❑ **Children Term Rider**
❑ **Elite**	$20,000	**plus**	$55,000	$75,000	$75,000	$10,000
❑ **Preferred**	$20,000	**plus**	$30,000	$50,000	$50,000	$10,000
❑ **Standard**	$20,000	**plus**	$5,000	$25,000	$25,000	$10,000

Premiums

Payment Mode	Premium and Fees	Total Premium and Fees
❑ A/C (Monthly) ❑ Semi-Annual ❑ Annual	Whole Life Policy $ _____ Term Rider with ROP $ _____ Accidental Death Rider $ _____ Children Term Rider $ _____ Policy Fee(s) $ _____	**$** _____

Additional Beneficiaries, Additional Covered Children and Other Information

PROPOSED INSURED AND OWNER'S STATEMENT: I have read the completed application. The representations are true to the best of my knowledge and belief. I understand and agree that the insurance applied for shall not be in effect unless the policy is issued by the Company during the Proposed Insured's lifetime. I further understand and agree that the Policy shall not be in effect until all eligibility requirements have been met and not until the Effective Date stated in the Policy. I understand that the information on the application will be relied upon to determine insurability and that incorrect information may result in coverage being voided and the policy rescinded, subject to the policy Incontestability Provision. I understand that the agent has no right to approve the application, change the policy, or waive any policy provision.

I acknowledge receipt of the following:

- Description of Information Practices,
- Fair Credit Reporting Act notification, and
- Disclosure Notice Concerning the Medical Information Bureau.

IMPORTANT NOTICE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signature of Proposed Insured	Signature of Proposed Owner (if other than the Proposed Insured)	Date

Application signed in: _____ City _____ State

AGENT'S STATEMENT: I certify that I have interviewed the Proposed Insured face-to-face, asked all of the questions contained in the application, accurately recorded the information supplied by the Proposed Insured, and I did not observe nor am I aware of any other information that might affect the insurability or underwriting class of the Proposed Insured.

Date: _____ Signature of Agent: _____ Agent #: _____

Order # _____ Signed in: _____ City _____ State

MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, MIB, Inc. or other organization, institution or person, that has any records or knowledge of me or my health, to give Family Heritage Life Insurance Company of America or its representatives or its reinsurers any such information. I understand that the information will be used to determine my insurability.

I authorize the Insurance Company or its reinsurers to disclose my personal health information to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and protection program.

I acknowledge that some states and federal law prohibit the further disclosure of drug related or HIV related information without my specific written consent. I hereby authorize Family Heritage, its representatives and its reinsurers to further disclose the foregoing information to the extent such disclosure is necessary in order to carry out the purpose of the original disclosure. A copy of this authorization shall be as valid as the original.

I agree that this authorization shall be valid for 24 months from the date signed and that I or my legal representative may request a copy of it. I understand that I may revoke this authorization at any time by notifying Family Heritage in writing but this right to revoke should not apply to any action taken by Family Heritage prior to receipt of the revocation or to any action taken in reliance upon the existence of the authorization.

_____
Signature of Proposed Insured

_____
Name (Please Print)

_____
Date

AUTHORIZATION TO HONOR DEDUCTIONS DRAWN BY
FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

Draft From: ❑ Checking ❑ Savings ❑ Third Party

Account in the name of:_____
(Print Name as Shown on Bank Documents)

Name of Bank and Branch:_____

City:_____State:_____

ACH Routing #:___ ___ ___ ___ ___ ___ ___ ___ ___ Account #:_____
(always 9 digits)

I (we) hereby authorize Family Heritage Life Insurance Company of America (Family Heritage) to initiate entries to my (our) checking/savings account at the financial institution listed above (The Financial Institution), and, if necessary, initiate adjustments for any transaction credited/debited in error. The authority will remain in effect until Family Heritage is notified by me (us) in writing to cancel it in such time as to afford Family Heritage and The Financial Institution a reasonable opportunity to act on it. Such writing will be sent by me (us) to Family Heritage at the Executive Office in Cleveland, Ohio.

I request that such deductions be drawn from my account on the_____day of each month.
(Note: the 29th, 30th, and 31st are not available dates)

Date_____ Signature of Bank Depositor_____

Affix a Voided Check or Deposit Slip Here

FAMILY HERITAGE®

Life Insurance Company Of America

Application For **Heritage Life Extra** Whole Life Insurance
Life Administrative Office: P.O. Box 5128, Frankfort, KY 40602-5128

Proposed Insured Information

First Name	MI	Maiden Name	Last Name	❑ Male ❑ Female
Date of Birth	Birthplace (City & State)	Height ft in	Current Weight lbs	
Phone Number ( ) -	SSN	Driver's License Number	Issue State	
Address	City	County	State	Zip Code
Primary Physician's Name	Address	Phone Number ( ) -		

Beneficiary Information

Primary Beneficiary Name	Relationship	SSN	Contingent Beneficiary Name	Relationship

Proposed Owner (If other than Proposed Insured)

First Name	MI	Last Name	SSN	Date of Birth	Relationship

Mailing Address	City	County	State	Zip Code	Phone Number ( ) -

Has the Proposed Insured:	**YES**	**NO**
1. In the past **2 years** used nicotine in any form including: cigarettes, cigars, pipe, chewing tobacco, snuff, gum, lozenge or patch?	❑	❑
2. Been actively at work (at least 30 hours per week) for the past **12 months** (excluding non-working spouses)?	❑	❑

Has the Proposed Insured or any Child to be covered under this policy:	**YES**	**NO**
3. In the past **12 months**, been confined for 24 hours or more, or been advised by a medical professional to be confined to a hospital, nursing home, psychiatric facility, or assisted living facility excluding i) confinements for: childbirth, gall bladder surgery, appendix surgery, broken bones or back problems; and ii) for which the proposed insured has completely recovered?	❑	❑
4. **Ever** had or been advised by a medical professional to have an organ or tissue transplant; of having any illness indicated as being terminal; or of having a life expectancy of two years or less?	❑	❑
5. In the past **10 years** been diagnosed with, treated for, or taken prescription drugs for any of the following:		
a. Cancer in any form other than basal cell skin cancer?	❑	❑
b. Chronic obstructive pulmonary disease (COPD), emphysema, pulmonary fibrosis, chronic bronchitis or chronic asthma (excluding mild asthma requiring occasional inhaler use)?	❑	❑
c. Heart disease (including heart attack, heart surgery, congestive heart failure, coronary artery disease or angina)?	❑	❑
d. Uncontrolled high blood pressure or malignant hypertension?	❑	❑
e. Insulin dependent diabetes?	❑	❑
f. Multiple sclerosis, Parkinson's disease, systemic lupus, or Lou Gehrig's disease (ALS)?	❑	❑
g. Kidney disease, liver disease, cirrhosis, chronic hepatitis, or hepatitis C?	❑	❑
h. Stroke, transient ischemic attack (TIA) or mini-stroke?	❑	❑
i. Alcohol or drug abuse?	❑	❑
j. Alzheimer's disease, dementia, organic brain syndrome, or brain tumor?	❑	❑
k. Major depression, bipolar disorder, or schizophrenia?	❑	❑
l. Down Syndrome, spina bifida, muscular dystrophy, or sickle cell anemia?	❑	❑
6. In the past **12 months,** been advised by a medical professional to have a diagnostic test or surgery that has not been performed or for which results have not been received?	❑	❑

Has the Proposed Insured or any Child to be covered under this policy:	YES	NO
7. Had a seizure of any type in the past **2 years**?	❑	❑
8. **Ever** been diagnosed with any immune deficiency including AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?	❑	❑
9. In the past **12 months** worked for pay as a timber cutter, logger, commercial fisherman, or aircraft pilot?	❑	❑
10. Within the past **3 years** been convicted of operating a vehicle while under the influence of drugs or alcohol, been convicted of reckless driving, or had a suspended or revoked driver's license?	❑	❑
11. **Ever** been convicted of a felony and currently in prison, on probation or on parole?	❑	❑

Other	YES	NO
12. Are you or any Child to be covered under this policy a permanent resident of the United States, the United States Protectorates or Canada?	❑	❑
13. Do you have any existing life insurance or annuity contracts in force? (If "Yes" complete a Replacement Form)	❑	❑
14. Do you give Family Heritage permission to show your name for marketing purposes?	❑	❑

Covered Children Information List the names of all children to be covered under this plan. (Additional space provided below if needed.)
Only dependent children are eligible.

Name (Please Print: First, Middle Initial, Last)	M/F	Date of Birth	Physician's Name

Ages 23 through 55					
	Whole Life		Term Rider With ROP	❑ Accidental Death Rider	❑ Children Term Rider
❑ **Elite 150**	$20,000	*plus*	$130,000	$150,000	$10,000
❑ **Elite 125**	$20,000	*plus*	$105,000	$125,000	$10,000
❑ **Elite 100**	$20,000	*plus*	$80,000	$100,000	$10,000
❑ **Elite**	$20,000	*plus*	$55,000	$75,000	$10,000
❑ **Preferred**	$20,000	*plus*	$30,000	$50,000	$10,000
❑ **Standard**	$20,000	*plus*	$5,000	$25,000	$10,000

Ages 56 and Older	
	Whole Life
❑ **Elite**	$75,000
❑ **Preferred**	$50,000
❑ **Standard**	$25,000

Premiums

Payment Mode	Premium and Fees	Total Premium and Fees
❑ A/C (Monthly) ❑ Semi-Annual ❑ Annual	Whole Life Policy $ _____ Term Rider with ROP $ _____ Accidental Death Rider $ _____ Children Term Rider $ _____ Policy Fee(s) $ _____	**$** _____

Additional Beneficiaries, Additional Covered Children and Other Information

PROPOSED INSURED AND OWNER'S STATEMENT: I have read the completed application. The representations are true to the best of my knowledge and belief. I understand and agree that the insurance applied for shall not be in effect unless the policy is issued by the Company during the Proposed Insured's lifetime. I further understand and agree that the Policy shall not be in effect until all eligibility requirements have been met and not until the Effective Date stated in the Policy. I understand that the information on the application will be relied upon to determine insurability and that incorrect information may result in coverage being voided and the policy rescinded, subject to the policy Incontestability Provision. I understand that the agent has no right to approve the application, change the policy, or waive any policy provision.

I acknowledge receipt of the following:

- Description of Information Practices,
- Fair Credit Reporting Act notification, and
- Disclosure Notice Concerning the Medical Information Bureau.

IMPORTANT NOTICE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signature of Proposed Insured	Signature of Proposed Owner (if other than the Proposed Insured)	Date

Application signed in: _____ (City) _____ (State)

AGENT'S STATEMENT: I certify that I have interviewed the Proposed Insured face-to-face, asked all of the questions contained in the application, accurately recorded the information supplied by the Proposed Insured, and I did not observe nor am I aware of any other information that might affect the insurability or underwriting class of the Proposed Insured.

Date: _____ Signature of Agent: _____ Agent #: _____

Order # _____ Signed in: _____ (City) _____ (State)

MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, MIB, Inc. or other organization, institution or person, that has any records or knowledge of me or my health, to give Family Heritage Life Insurance Company of America or its representatives or its reinsurers any such information. I understand that the information will be used to determine my insurability.

I authorize the Insurance Company or its reinsurers to disclose my personal health information to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and protection program.

I acknowledge that some states and federal law prohibit the further disclosure of drug related or HIV related information without my specific written consent. I hereby authorize Family Heritage, its representatives and its reinsurers to further disclose the foregoing information to the extent such disclosure is necessary in order to carry out the purpose of the original disclosure. A copy of this authorization shall be as valid as the original.

I agree that this authorization shall be valid for 24 months from the date signed and that I or my legal representative may request a copy of it. I understand that I may revoke this authorization at any time by notifying Family Heritage in writing but this right to revoke should not apply to any action taken by Family Heritage prior to receipt of the revocation or to any action taken in reliance upon the existence of the authorization.

_____
Signature of Proposed Insured

_____
Name (Please Print)

_____
Date

AUTHORIZATION TO HONOR DEDUCTIONS DRAWN BY
FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

Draft From: ❑ Checking ❑ Savings ❑ Third Party

Account in the name of:_____
(Print Name as Shown on Bank Documents)

Name of Bank and Branch:_____

City:_____State:_____

ACH Routing #:___ ___ ___ ___ ___ ___ ___ ___ ___ Account #:_____
(always 9 digits)

I (we) hereby authorize Family Heritage Life Insurance Company of America (Family Heritage) to initiate entries to my (our) checking/savings account at the financial institution listed above (The Financial Institution), and, if necessary, initiate adjustments for any transaction credited/debited in error. The authority will remain in effect until Family Heritage is notified by me (us) in writing to cancel it in such time as to afford Family Heritage and The Financial Institution a reasonable opportunity to act on it. Such writing will be sent by me (us) to Family Heritage at the Executive Office in Cleveland, Ohio.

I request that such deductions be drawn from my account on the_____day of each month.
(Note: the 29th, 30th, and 31st are not available dates)

Date_____ Signature of Bank Depositor_____

Affix a Voided Check or Deposit Slip Here

FAMILY HERITAGE®
Life Insurance Company Of America

DISCLOSURE NOTICE CONCERNING THE MIB, INC.

Information regarding your insurability will be treated as confidential. Family Heritage Life Insurance Company of America, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of insurance companies, which operates as an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Family Heritage Life Insurance Company of America, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

DESCRIPTION OF INFORMATION PRACTICES

This description of the Information Practices of Family Heritage Life Insurance Company of America and your Family Heritage Agent is being provided in accordance with the requirements of the Insurance Information and Privacy Protection Law in effect in your state of residence. In order to properly underwrite and administer your insurance coverage, we must collect a certain amount of necessary and helpful information. The amount and type of information collected may vary depending on the amount and type of coverage applied for, but in general we will be seeking information about your age, occupation, physical condition, health history, mode of living, avocations and other personal characteristics. In addition, your Family Heritage Agent may collect information intended to aid in the updating and improvement of your insurance program. You are our most important source of information, but we may also collect or verify information by contacting medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employers and business associates, friends and neighbors, and other insurance companies to which you have applied. We may collect information by exchanges of correspondence, by phone or personal contact. In some cases, we may ask an insurance support organization to collect information and submit an investigative consumer report to us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services. Upon your written request, you have a right to access and correct any personal information obtained, and you may request to receive the specific reason for any adverse underwriting decision.

FAIR CREDIT REPORTING ACT

Public Law 91-508 requires that we advise you that an investigative consumer report may be made in connection with this application which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors and associates. Upon written request a complete and accurate disclosure of the "nature and scope" of the report if one is made will be provided. You have the right to be interviewed in connection with any report prepared and to receive a copy of the report upon your written request.

CONDITIONAL RECEIPT

(Do not complete and give to Applicant unless payment is made)

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO
FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

This receipt is given on behalf of Family Heritage Life Insurance Company of America having received the sum

of $_____ from _____for coverage on the Proposed

Insured_____ . In exchange for the payment of the first required premium with the application, the Company will provide insurance prior to policy delivery, subject to the completion of all of the following conditions: The premium specified on the application has been tendered; a later effective date has not been requested; the Proposed Insured is acceptable to the Company under its rules and practices for the plan and amount applied for at the rate class applied for; and, there are no material misrepresentations on the application. The amount of insurance provided by this receipt is the lesser of the initial death benefit of the insurance applied for in the application or $150,000.

If any condition under this receipt is not met, or the Proposed Insured dies by suicide**,** the Company's only liability will be to refund the premium payment. Either the Company or the Proposed Owner may terminate coverage under this receipt by notice to the other. Once begun, any insurance this receipt may provide ends at the earliest of: (1) 60 days after the date of the application; (2) when the Company sends a refund of the premium which was exchanged for this receipt; or, (3) the date any policy issued goes into effect.

I have read and agree to the above terms.

Date_____ Signature of Proposed Owner _____

Date_____ Signature of Licensed Company Representative _____

Family Heritage Life Insurance Company of America
Life Administrative Office
P.O. Box 5128 • Frankfort, KY • 40602-5128 • 877-694-8705

CONSUMER INFORMATION NOTICE

If you have a question about your policy, if you need assistance, or if you have a claim, please contact:

Family Heritage Life Insurance Company of America
Life Administrative Office
P.O. Box 5128
Frankfort, Kentucky 40602-5128
Toll Free 877-694-8705

<Name of Agent From Mainframe>
<Agent Address Line 1 From Mainframe>
<Agent Address Line 2 From Mainframe>

If we at Family Heritage Life Insurance Company of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
Phone Number 1(800) 852-5494 or (501) 371-2640

SERFF Tracking Number:	*FHLA-128460058*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:	*ARL4APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Whole Life Applications*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Form AR-GUAR (attached - approved by the Department on 8/6/1999 & later revised with required updates) is the form issued to all Arkansas policyholders pursuant to Rule & Regulation 49.

Form L4CIN-AR (which is part of this filing) is our Consumer Information Notice and will be issued to all Arkansas policyholders.

The Flesch Readability Certification is attached.

The Certification for Rule & Regulation 19 is attached.

Attachments:

AR-GUAR.pdf

FORM L4CIN-AR.pdf

Readability Cert.pdf

Rule & Reg 19 Cert.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: This is an application filing.

Comments:

Item Status: **Status Date:**

Bypassed - Item: Life & Annuity - Acturial Memo

Bypass Reason: N/A

Comments:

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rates yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or a similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy of contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

CONSUMER INFORMATION NOTICE

If you have a question about your policy, if you need assistance, or if you have a claim, please contact:

Family Heritage Life Insurance Company of America
Life Administrative Office
P.O. Box 5128
Frankfort, Kentucky 40602-5128
Toll Free 877-694-8705

<Name of Agent From Mainframe>
<Agent Address Line 1 From Mainframe>
<Agent Address Line 2 From Mainframe>

If we at Family Heritage Life Insurance Company of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
Phone Number 1(800) 852-5494 or (501) 371-2640

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Family Heritage Life Insurance Company of America

I hereby certify that the following forms meet the minimum reading ease score of 40 on the Flesch Reading Ease Test and that they comply with the requirements of ACA 23-80-206, cited as the Life and Accident and Health Insurance Policy Language Simplification Act.

Form Number	Description
FORM H4APP-AR2	Ind. Whole Life Application
FORM H5APP-AR	Ind. Whole Life Application
FORM H4SPP-AR2	Conditional Receipt / MIB Disclaimer

Signature

Henry G. Grendell
Name

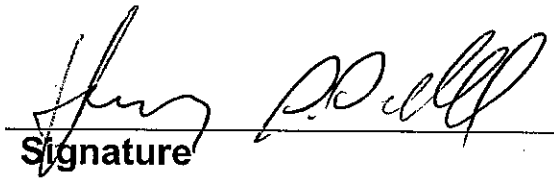
Vice President & General Counsel
Title

June 7, 2012
Date

FAMILY HERITAGE®
Life Insurance Company Of America

Certification of Compliance with Rule and Regulation 19

I hereby certify that this submission (Form L4APP-AR2, et al) meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.



Signature

Henry G. Grendell
Name

Vice President & General Counsel
Title

June 7, 2012
Date

P.O. Box 470608 • Cleveland, Ohio 44147

(440) 922-5200 FAX: (440) 922-5201